

# Data Specification Manual

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## 957 CMR 2.00: Payer Reporting of Alternative Payment Methods

March 14, 2014

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## Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis (“Center”) to collect from private and public health care payers “data on changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies” and “the average negotiated monthly or yearly budget weighted by member months for each geographic region of the commonwealth.” M.G.L. c. 12C, § 16 further directs the Center to collect “the proportion of health care expenditures reimbursed under fee-for-service (FFS) and alternative payment methodologies.”

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to report this data to the Center. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit one Alternative Payment Methods (APM) file to the Center annually. The file will contain payment method data for the previous calendar year. Files can only contain data for one year. Files will contain different record types, including:

- a. Payer Comments
- b. Separate alternative payment methods data with distinct lines for Medicare Advantage; Medicaid & Medicaid Managed Care (MCO); Commonwealth Care; Commercial Full claims; Commercial Partial claims; Medicare and Medicaid Dual-Eligibles, 65 and over; Medicare and Medicaid Dual-Eligibles, 18-64; and Other by:
  - Provider Organization
  - Zip Code

## File Submission Instructions and Schedule

Payers will submit flat files with alternative payment method data via INET. The fields are variable length and relative to position; therefore, they need to be separated by an asterisk (\*). Payers will submit this information on an annual basis. Payers will have an opportunity to review the final calculation before it is reported on the Center’s website.

Payers will submit APM data in accordance with regulation 957 CMR 2.00 on the following schedule:

Alternative Payment Methods Filing Schedule	
Date	File Due
May 15, 2014	CY 2013 Alternative Payment Methods

## Data Submission

For the reporting of claims payments, payers shall report the allowed dollar amounts, i.e. provider payment and any patient cost-sharing amount. Payers shall only report claims data for which they are the primary payer and exclude any paid claims for which it was the secondary or tertiary payer.

Payers shall allocate non-claims payments by member months for zip-code level reporting.

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For both provider level and zip code level reporting, payers must report data for **all Massachusetts residents** based on zip code of residence as of the last day of the reported year, December 31<sup>st</sup>, or the last day in the payer's network. For the assignment of payment methods, payers shall allocate the payment method and payment amount by member month and follow the allocation logic shown in Appendix A.

Payers must report the APM data assuming a neutral health status adjustment score of 1.0 using an industry accepted health status adjustment tool.

For payment method assignment, payers will classify payment methods for physician groups and members based on the payment method allocation hierarchy: (1) global payment; (2) limited budget; (3) bundled payment; (4) other, non-FFS based; and (5) FFS. APMs can be layered on a FFS structure, wherein a fee-for-service mechanism is used for claims processing and payment transaction purposes. The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization. For example, for a member whose managing physician group is under a global payment contract, the dollar amount associated with this member should be classified as global payments even though the payer utilizes a FFS payment mechanism to reimburse providers at the transactional level and then conducts a financial settlement against the spending target at the end of the year. The same logic applies to limited budget or bundled payment arrangements.

### **Provider Level Reporting**

For calendar year 2014 reporting of the calendar year 2013 data, payers may use contracting entity IDs (this is the highest level according to payer's contracting structure) to best mimic how they will report physician groups when they register with the Health Policy Commission as Registered Provider Organizations. Payers shall report contracting entities that have at least 36,000 Massachusetts member months attributed to them. Payers must report separate lines for the affiliated parent physician groups underneath the contracting entity if the parent physician group has more than 36,000 member months. Payers must report separate lines for the affiliated local practice groups underneath the parent physician groups and contracting entity if the local practice group has greater than 36,000 member months. If the contracting entity's affiliated parent physician groups and local practice groups do not individually meet the 36,000 member month threshold, then payers must report the data in aggregate using OrgID 999997 in the parent physician group and local practice group OrgID fields. Payers must report all contracting entities that do not meet the 36,000 member month threshold in aggregate using OrgID 999996.

Payers shall only report data for Massachusetts residents, based on the member's zip code as of the last day of the reporting year, December 31<sup>st</sup>. For the provider level reporting, payers shall report APM data by highest level of contracting structure of provider organizations for those members whom the payer is able to attribute to a provider organization. For members whose insurance products require the selection of primary care physicians (PCPs), the payer should allocate the members based on their PCP's provider organizations. For members whose insurance products do not require the selection of PCPs, the payer should allocate these members to appropriate provider organizations based on the payer's own member attribution/assignment logic.

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If the payer holds more than one contract type using different payment methods with a contracting entity level / registered provider organization, then the payer must separately report the APM data by each type of contract.

### **Zip - Code Level Reporting**

For zip-code level data, payers must report APM data by zip code for all Massachusetts members based on the zip code of the member, as of the last day of the reporting period. The Center shall not publicly report zip code APM data unless aggregated to an amount appropriate to protect patient confidentiality.

### **Field Definitions: Provider Level**

Contracting Entity ID: In the future the Registered Provider Organization ID will be assigned by the Health Policy Commission for the Registered Provider Organization. For CY 2014 data, payers must submit CHIA-issued OrgIDs. If a payer cannot find an OrgID for their contracting entity, then the payer should request one from CHIA. A Contracting Entity is defined as “the provider who holds a contract with the payer and is paid for services in accordance with a payment model based on a prospectively or retrospectively defined budget.”

Physician Group OrgID: The OrgID assigned by the Center for the Physician Parent Group. Refer to Appendix B for the number associated with the Physician Parent Group.

Local Practice Group OrgID: The OrgID assigned by the Center for the Local Practice Group. Refer to Appendix B for the number associated with the Local Practice Group.

Insurance Category Code: A number that indicates the reported insurance category.

<b>Insurance Category Code</b>	<b>Definition</b>
<b>1</b>	<b>Medicare &amp; Medicare Advantage</b>
<b>2</b>	<b>Medicaid &amp; Medicaid MCO</b>
<b>3</b>	<b>Commercial: Full-Claim</b>
<b>4</b>	<b>Commercial: Partial Claim</b>
<b>5</b>	<b>Commonwealth Care</b>
<b>6</b>	<b>Medicare and Medicaid Dual-Eligibles, 65 and over</b>
<b>7</b>	<b>Medicare and Medicaid Dual-Eligibles, 18-64</b>
<b>8</b>	<b>Other (MSP, SCO, PACE, Bridge)</b>

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Product Type: The product type under the insurance category reported.

<b>Product Type Code</b>	<b>Definition</b>
<b>1</b>	<b>HMO and POS</b>
<b>2</b>	<b>PPO</b>
<b>3</b>	<b>Indemnity</b>
<b>4</b>	<b>Other (e.g. EPO)</b>

Payment Method: Payments will be reported by payment method, as defined below.

*Global Budget/Payment*: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services.

Examples include shared savings and full/partial risk arrangements. The global budget/payment method should be separated into two categories: (1) Global Budget/Payment Full Benefits and (2) Global Budget/Payment Partial Benefits. Global Budget/Payment Full Benefits contains the budget and payment data for a comprehensive set of services. Global Budget/Payment Partial Benefits contains the budget and payment data for a defined set of services, where certain benefits such as behavioral health services or prescription drugs are carved out and not part of the budget. If you are reporting a physician group contract that has a carve-out service, then you would report that line twice, once as 1A with the full dollar amount, including carve-out payments, and then again as 1B with the carve-out payments excluded. The data line for payment method 1B will be a subset of the data line for payment method 1A.

*Limited Budget*: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

*Bundled Payments*: Payment arrangements where budgets for health care spending are set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types.

*Other, non-FFS based*: All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

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*Fee for Service (FFS):* A payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payments.

Payment Method Code	Definition
1A	Global Budget/Payment (Full Benefits: budget includes comprehensive services)
1B	Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based
5	Fee for Service

Member Months: The number of members participating in a plan over the specified period of time expressed in months of membership.

Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

Average Monthly Budget: The total budgeted amount divided by the number of member months under a given contract. If the contracted budget does not align with the calendar year, annualize the budget by the appropriate member months. If the average monthly budget is not set in the contract, then calculate the amount by dividing the total spending associated with the member under the contract by the member months. Please note that this field only applies to global and limited budget payment arrangements.

Total Claims Payments: The sum of all associated claims payments, including patient cost sharing amounts, for each insurance category, product type, and payment method combination.

Total Non-Claims Payments: The sum of all associated non-claims payments for each insurance category, product type, and payment method combination.

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**Total Payments:** The sum of Total Claims Payments and Total Non-Claims Payments.

**Amount of Total Payments due to Financial Performance Measures:** The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination. A financial performance payment is defined as additions to the base payment or adjustments to a contracted payment amount made based solely on the achievement of financial or cost-based measures.

**Amount of Total Payments due to Quality Performance Measures:** The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination. A quality performance payment is made either as an addition to the base payment or as an adjustment to a contracted payment amount, in both cases to reward a provider for quality, access and/or patient experience. Quality performance-based contracts do not include contracts that incorporate payment adjustments based solely on provider cost or efficiency performance.

**Amount of Total Payments due to Financial and Quality Performance Measures Combined:** The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination. These include contracts that incorporate payment adjustments based on linked financial and quality performance measures. This category is only applicable for contracts that do not separately consider a provider's financial and quality performance in payment adjustments.

**Field Definitions: Zip Code Level**

**Zip Code:** Five digit Massachusetts zip-code to which members are attributed. Select from roster in Appendix C.

**Insurance Category Code:** A number that indicates the reported insurance category.

<b>Insurance Category Code</b>	<b>Definition</b>
<b>1</b>	<b>Medicare &amp; Medicare Advantage</b>
<b>2</b>	<b>Medicaid &amp; Medicaid MCO</b>
<b>3</b>	<b>Commercial: Full-Claim</b>
<b>4</b>	<b>Commercial: Partial Claim</b>
<b>5</b>	<b>Commonwealth Care</b>
<b>6</b>	<b>Medicare and Medicaid Dual-Eligibles, 65 and over</b>
<b>7</b>	<b>Medicare and Medicaid Dual-Eligibles, 18-64</b>
<b>8</b>	<b>Other (MSP, SCO, PACE, Bridge)</b>



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**Product Type:** The product type under the insurance category reported.

<b>Product Type Code</b>	<b>Definition</b>
<b>1</b>	<b>HMO and POS</b>
<b>2</b>	<b>PPO</b>
<b>3</b>	<b>Indemnity</b>
<b>4</b>	<b>Other (e.g. EPO)</b>

**Payment Method:** Payments will be reported by payment method, as defined below.

*Global Budget/Payment:* Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services.

Examples include shared savings and full/partial risk arrangements. The global budget/payment method should be separated into two categories: (1) Global Budget/Payment Full Benefits and (2) Global Budget/Payment Partial Benefits. Global Budget/Payment Full Benefits contains the budget and payment data for a comprehensive set of services. Global Budget/Payment Partial Benefits contains the budget and payment data for a defined set of services, where certain benefits such as behavioral health services or prescription drugs are carved out and not part of the budget. If you are reporting a physician group contract that has a carve-out service, then you would report that line twice, once as 1A with the full dollar amount, including carve-out payments, and then again as 1B with the carve-out payments excluded. The data line for payment method 1B will be a subset of the data line for payment method 1A.

*Limited Budget:* Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

*Bundled Payments:* Payment arrangements where budgets for health care spending are set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types.

*Other, non-FFS based:* All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

*Fee for Service (FFS):* A payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance

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measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payments.

<b>Payment Method Code</b>	<b>Definition</b>
<b>1A</b>	<b>Global Budget/Payment (Full Benefits: budget includes comprehensive services)</b>
<b>1B</b>	<b>Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)</b>
<b>2</b>	<b>Limited Budget</b>
<b>3</b>	<b>Bundled Payments</b>
<b>4</b>	<b>Other, non-FFS based</b>
<b>5</b>	<b>Fee for Service</b>

Member Months: The number of members participating in a plan over the specified period of time expressed in months of membership.

Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

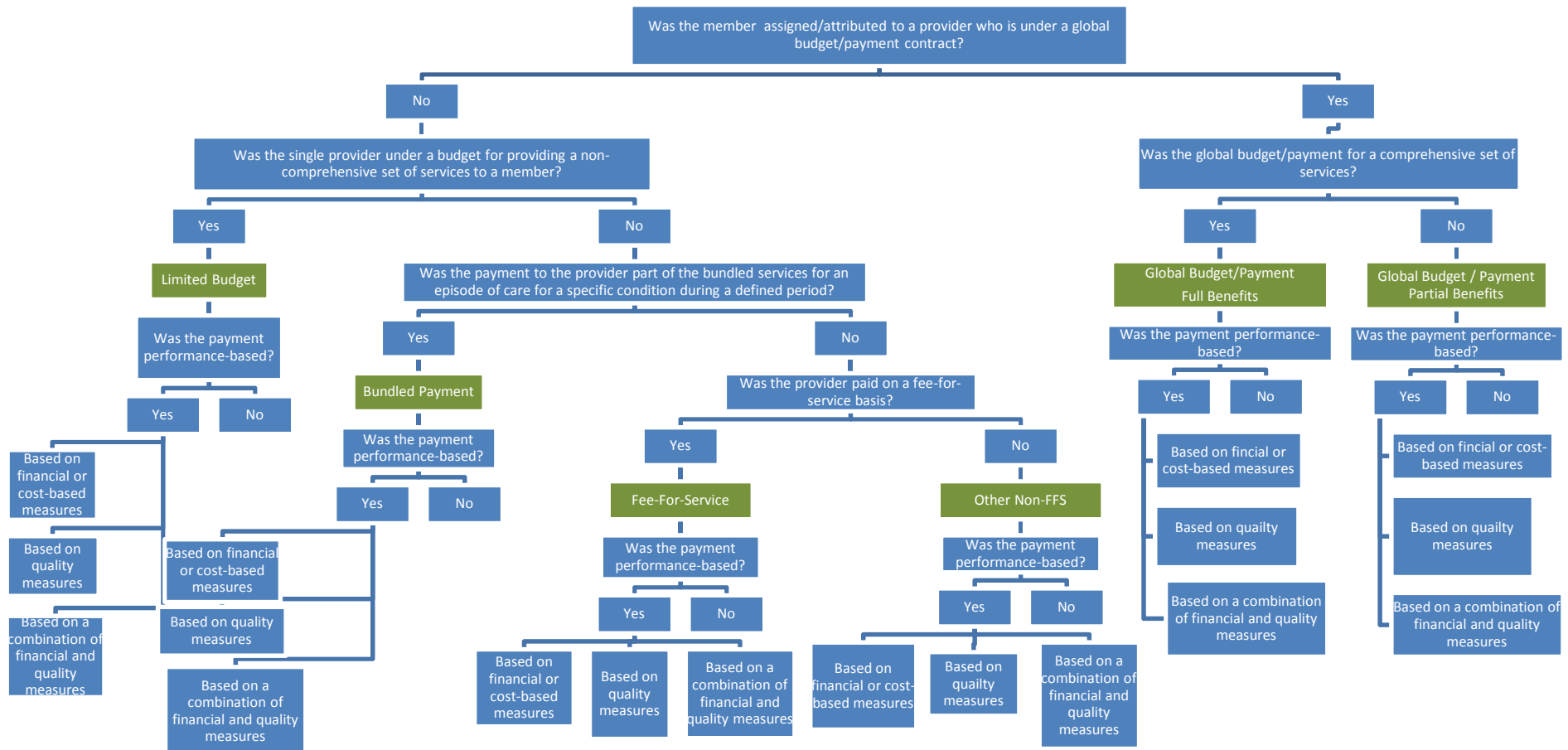
Total Payments: The sum of all associated payments for each insurance category, product type, and payment method combination. This includes both provider claims and non-claims payments and any patient cost sharing amounts.

*For detailed information on data submission, please see Appendix D.*

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Appendix A: Payment Method Allocation Logic

Payment Method



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**Appendix B. Physician Group OrgIDs**

Please visit:

<http://www.mass.gov/chia/researcher/hcf-data-resources/payer-data-reporting/total-medical-expenses-filing-information.html>

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**Appendix C. Massachusetts Zip Codes**

Please visit:

<http://www.mass.gov/chia/researcher/hcf-data-resources/payer-data-reporting/total-medical-expenses-filing-information.html>

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**Appendix D: Data Submission Guidelines**

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-APM	1	HD001	Record Type	10/28/13	Text	HD	2	Yes	This must have HD reported here. Indicates the beginning of the Header Record
HD-APM	2	HD002	Payer	10/28/13	Integer	#####	8	Yes	This is the Carriers ORG ID. This must match the Submitters ORG ID
HD-APM	3	HD003	National Plan ID	10/28/13	Text		30	No	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
HD-APM	4	HD004	Type of File	10/28/13	Integer	####	4	Yes	This must have 147 reported here. This is an indicator that defines the type of file and the data contained within the file.
HD-APM	5	HD005	Period Beginning Date	10/28/13	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the start date period of the reported period in the submission file.
HD-APM	6	HD006	Period Ending Date	10/28/13	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date.
HD-APM	7	HD007	Provider Record Count	10/28/13	Integer	#####	10	Yes	Record Count for APM by Provider
HD-APM	8	HD008	Zip code Record Count	10/28/13	Integer	#####	10	Yes	Record Count for APM by Zip Code

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-APM	9	HD009	Comments	10/28/13	Text	Free Text Comments	255	No	Provider APM Comments
HD-APM	10	HD010	Comments	10/28/13	Text	Free Text Comments	255	No	Zip Code APM Comments
HD-APM	11	HD011	Comments	10/28/13	Text	Free Text Comments	255	No	Other Comments to support the submission data
HD-APM	12	HD012	Health Status Adjustment Tool	10/28/13	Text	Text	80	Yes	The health status adjustment tool, software or product used to calculate the health status adjustment score
HD-APM	13	HD013	Health Status Adjustment Version	10/28/13	Text	Text	20	Yes	The version number of the health status adjustment tool used to calculate the health status adjustment score
HD-APM	14	HD014	Submission Type	10/28/13	Text	Flag	1	Yes	Type of Submission file T= Test; P = Production
PL	1	PL001	APM Record Type ID	10/28/13	Text	Text	2	Yes	This must have PL reported here. Indicates the beginning of the Provider based APM record
PL	2	PL002	Contracting Entity ID	10/28/13	Integer	#####	5	Yes	Contract Entity ID—ID assigned by payer for the highest level of contracting structure.  Must be a CHIA-issued OrgID.  For aggregation of all other sites that fall below the threshold, use OrgID <b>999996</b> .
PL	3	PL003	Physician Group Org ID	10/28/13	Integer	#####	6	Yes	Org ID (Owning entity – Same value of site if self-owned).  Must be a CHIA-issued OrgID.



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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									For aggregation of sites that fall below threshold, but that are part of a larger contracting entity, use OrgID <b>999997</b> . For aggregation of sites that fall below the threshold and that do not belong to a larger contracting entity, use ORGID <b>999996</b> .  Note: If PL002=999996, then PL003 must also equal 999996.
PL	4	PL004	Local Practice Group Org ID	10/28/13	Integer	#####	6	Yes	Local Practice Group OrgID  Must be a CHIA-issued OrgID.  For aggregation of sites that fall below threshold, but that are part of a larger parent organization, use ORGID <b>999997</b> . For aggregation of sites that fall below the threshold and that do not belong to a larger parent organization, use ORGID <b>999996</b> .  Note: If PL003 = 999997, then PL004 must also equal 999997. If PL003 = 999996, then PL004 = 999996
PL	5	PL005	Pediatric Indicator	10/28/13	Integer	#	1	Yes	Indicates pediatric care  0 = No, 1 = Yes  Value must be either a '0' or '1'.
PL	6	PL006	Insurance Category Code	10/28/13	Integer	#	1	Yes	Indicates the insurance category that is being reported :  1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5 = Commonwealth Care 6= Medicare and Medicaid Dual-Eligibles, 65 and over

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									7 = Medicare and Medicaid Dual-Eligibles, 18-64 8 = Other (MSP, SCO, PACE, Bridge)  Value must be an integer between '1' and '8'.
PL	7	PL007	Product Type Code	10/28/13	Integer	#	1	Yes	Indicates the product type that is being reported:  1= HMO and POS 2= PPO 3= Indemnity 4= Other (e.g. EPO)  Value must be an integer between '1' and '4'.
PL	8	PL008	Payment Method	10/28/13	Text	Text	2	Yes	Indicates the payment method that is being reported:  1A = Global Budget/Payments (Full) 1B = Global Budget/Payments (Partial) 2=Limited Budget 3=Bundled Payments 4=Other, non-FFS based 5= Fee for Service
PL	9	PL009	Member Months	10/28/13	Integer	#####	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership.  No negative values.
PL	10	PL010	Health Status Adjustment Score	10/28/13	Number	##.##	6	Yes	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.  No negative values. Number must be between '.2' and '10'.

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PL	11	PL011	Average Monthly Budget per Member	10/28/13	Money	##.##	6	No	Total budgeted amount divided by the number of member months under a given contract. If the contracted budget does not align with calendar year annualize by the appropriate member months.  Only applies to global budget and limited budget payment arrangements.  No negative values.
PL	12	PL012	Total Claims Payments	10/28/13	Money	#####.##	12	Yes	Total Allowed Claims Payments  No negative values. Only one PL012 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.
PL	13	PL013	Total Non-Claims Payments						Total Non-Claims Payments  Only one PL013 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.
PL	14	PL014	Total Payments	10/28/13	Money	#####.##	12	Yes	Total Claims + Non-Claims Payments  No negative values. Only one PL014 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.
PL	15	PL015	Payments due to Financial Performance Measures	10/28/13	Money	#####.##	12	Yes	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination  Only one PL015 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PL	16	PL016	Payments due to Quality Performance Measures	10/28/13	Money	#####.##	12	Yes	The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination  Only one PL016 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.
PL	17	PL017	Total Payments due to Financial and Quality Performance Measures Combined	10/28/13	Money	#####.##	12	Yes	The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination  These include contracts that incorporate payment adjustments based on linked financial and quality performance  Only one PL017 for every PL002 / PL003 / PL004 / PL005 / PL006 / PL007 / PL008 combination.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
ZL	1	ZL001	APM Record Type ID	10/28/13	Text	ID	2	Yes	This must have ZL reported here. Indicates the beginning of the Zip Code based APM record
ZL	2	ZL002	Zip Code	10/28/13	Integer	#####	5	Yes	Zip Code Must be a valid MA zip-code.
ZL	3	ZL003	PCP Indicator	10/28/13	Integer	#	1	Yes	Indicates Primary Care Physician Enrollment

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									0 = No 1 = Yes  Value must be either a '0' or '1'.
ZL	4	ZL004	Insurance Category Code	10/28/13	Integer	#	1	Yes	Indicates the insurance category that is being reported :  1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5 = Commonwealth Care 6= Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 18-64 8 = Other (MSP, SCO, PACE, Bridge)  Value must be an integer between '1' and '8'.
ZL	5	ZL005	Product Type	10/28/13	Integer	#	1	Yes	Indicates the product type that is being reported:  1= HMO and POS 2= PPO 3= Indemnity 4= Other (e.g. EPO)  Value must be an integer between '1' and '4'.
ZL	6	ZL006	Payment Method	10/28/13	Text	Text	2	Yes	Indicates the payment method that is being reported:  1A = Global Budget/Payments (Full) 1B = Global Budget/Payments (Partial) 2=Limited Budget 3=Bundled Payments 4=Other, non-FFS based 5= Fee for Service

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
ZL	7	ZL007	Member Months	10/28/13	Integer	#####	9	Yes	Number of members participating in a plan over a specified period of time expressed in months of membership.  No negative values.
ZL	8	ZL008	Health Status Adjustment Score	10/28/13	Number	##.##	6	Yes	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.  No negative values. Number must bet between '.2' and '10'.
ZL	9	ZL009	Total Payments	10/28/13	Money	#####.##	12	Yes	The sum of all associated payments for each insurance category, product type, and payment method combination.  This includes both provider claims and non-claims payments and any patient cost sharing amounts.  No negative values. Only one ZL009 for every ZL002 / ZL003 / ZL004 / ZL005 / ZL006 combination.

**Note:** Any Required Integer, Number or Money field must have at least a zero in its place.

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**Table A. Insurance Category**

ID	Description
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid MCO
3	Commercial – Full Claims
4	Commercial—Partial Claims
5	Commonwealth Care
6	Medicare and Medicaid Dual-Eligibles, 65 and over
7	Medicare and Medicaid Dual-Eligibles, 18-64
8	Other (MSP, SCO, PACE, Bridge)

**Table B. Product Type**

ID	Description
1	HMO and POS
2	PPO
3	Indemnity
4	Other (e.g. EPO)

**Table C. Payment Method**

ID	Description
1A	Global Budget/Payment (Full)
1B	Global Budget/Payment (Partial)
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based (e.g. PCMHI)
5	Fee For Service

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***File Submission Naming Conventions***

Chapter 224 data submissions should follow the following naming conventions:

**SubmissionType\_YYYY\_Version.dat,**

Where Submission Type is one of the following:

APM224 for Chapter 224 Alternative Payment Methods data submissions

YYYY is the four digit year

Version is **optional**, and indicates the submission number.

The file extension must be .dat ( or .DAT)

**Below are examples of validly named files:**

APM224\_2014\_01.dat or apm224\_2014\_1.dat or apm224\_2014.dat